STATEMENT OF

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PARALYZED VETERANS OF AMERICA

REGARDING

THE REPORT OF

THE PRESIDENT'S TASK FORCE TO IMPROVE HEALTH CARE DELIVERY FOR OUR NATION'S VETERANS

BEFORE THE

HOUSE COMMITTEE ON VETERANS' AFFAIRS

JUNE 17, 2003

Chairman Smith, Ranking Member Evans, Members of the Committee, thank you for affording me the opportunity to present the views of the Paralyzed Veterans of America (PVA) on the final report of the President's Task Force to Improve Health Care Delivery for our Nation's Veterans (PTF).

PVA has closely monitored the PTF's progress. We have attended meetings and testified last year. Likewise, we testified before two House subcommittees last year regarding sharing between the Departments of Defense (DOD) and Veterans Affairs (VA). We have consistently advocated for sharing between the two health care systems when feasible and in the best interests of the patients who look to these diverse systems for health care. But we have also stated clearly and unequivocally that these systems must maintain their separate and unique identities. As we stated in our testimony before the PTF on January 15, 2002:

> VA typically treats a population of older Americans, chronically ill and disabled veterans. As the Nation's leader in such specialized services as blind rehabilitation, spinal cord injury, and mental health, the VA provides the full continuum of health care to veterans, from nursing homes and assisted living in long-term care facilities, to adult daycare and geriatric services. VA prosthetics and research provide services and innovations unmatched in other health care environments. These missions too, are unique to U.S. medicine and could be threatened if some form of merger were to take place between VA and DOD.
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> Typically, DOD medical facilities treat younger and much healthier patients. DOD facilities have expertise in prenatal, obstetrics, and pediatrics for family members and our active duty military. When DOD beneficiaries acquire conditions typically treated by VA, they are discharged and therefore become eligible for enrollment as VA beneficiaries. This is another example of how the two Departments do work together, but also why, in fact, they are unique entities.

We were pleased to see that the PTF has not recommended a merging of the two health care systems, but we do note that these systems, for all intents and purposes, will be merged if veterans and DOD beneficiaries have their choices limited, and their health care options diminished. We note that the PTF stated that:

> Without question, the two Departments have separate functions driven by their core missions that should remain distinct and freestanding. However, other functions are prime candidates for the development of common standards, creation of interoperable and interchangeable program elements, and joint

> development and operation of functional elements in the name of increased efficiency, cost avoidance, and improved access for beneficiaries.

Also in our testimony from last year, we stated that:

> PVA recognizes there are many areas of VHA/DOD sharing that could provide significant advantages, such as joint purchasing of pharmaceuticals, supplies and equipment. Additionally, there is a need for improved information exchange between the two systems. We do not, however, believe that there are any savings to be gained by forcing patients of one system to use the facilities of the other. While many local arrangements work to improve access and convenience of veterans and DOD beneficiaries, we do not see any need for a national initiative to force increased cross-system patient care. Beneficiaries of both systems must maintain the full range of health care choices.

We notice that many of the recommendations contained in the PTF report in chapter 4 contain explicit recommendations regarding how the two systems can save taxpayer dollars by joint purchasing arrangements. We were also heartened to see attention paid to facility upkeep and planning, issues similar to what PVA has recently testified to concerning VA construction. Indeed, there are many recommendations in this report that make sense.

PVA believes that the bottom line in any VA/DOD sharing effort is that the health care accorded to veterans and DOD beneficiaries is improved, not solely just because there is efficiency here, or a cost-savings there. These are important, but they are only a step toward the larger goal of improving patient care and options. It is in this light that we judge any recommendation put forward as to the efficacy, and desirability, of VA/DOD sharing.

PVA views Chapter Five of the final report, "Timely Access to Health Services and the Mismatch between Demand and Funding," as the crux of the PTF's recommendations. We were pleased to see the PTF attempt to tackle these vital issues, but we think that they did not go far enough.

Recommendation 5.2 reads that "VA facilities should be held accountable to meet the VA's access standards for enrolled Priority Groups 1 through 7 (new). In instances where an appointment cannot be offered within the access standard, VA should be required to arrange for care with a non-VA provider, unless the veteran elects to wait for an available appointment within VA."

Access is indeed a critical concern of PVA. As *The Independent Budget for Fiscal Year 2004* states:

> According to VA, the number of veterans using VA's health-care system has risen dramatically in recent years, increasing from 2.9 million in 1995 to a projected 4.5 million in 2002. An additional 600,000 veterans are projected to enroll in VA health care in 2003. Unfortunately, VA health-care resources do not meet the increased demand for services and the system is unable to absorb this significant increase. With more than 235,000 veterans on a waiting list, waiting at least six months or more for care, VA has now reached capacity at many health-care facilities and closed enrollment to new patients at many hospitals and clinics. Additionally, VA has placed a moratorium on all marketing and outreach activities to veterans and determined there is a need to give the most severely service-connected disabled veterans a priority for care.
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> Though caring for veterans with service-connected disabilities is a core commitment for VA, this does not provide timely access to quality health care for all eligible veterans who were authorized access to VA health care under the provisions of the Health Care Eligibility Reform Act of 1996. To ensure that all service-connected disabled veterans, and all other enrolled veterans, are able to access the system in a timely manner, it is imperative that our government provide an adequate health-care budget to enable VA to serve the needs of veterans nationwide.

Access standards without sufficient funding are standards in name only. In addition, although we applaud the PTF for bringing up the importance of access standards, we have concerns over the recommended enforcement method – arranging for care to be provided at non-VA providers when these standards are not met. The VA is a national asset, and steps taken to shift patients to non-VA providers can set a dangerous precedent, encouraging those who would like to see the VA privatized and the federal government turning its back on its promises to the men and women who have served. We do think that access standards are important, but we believe that the answer is in providing sufficient funding in the first place in order to negate the impetus driving health care rationing.

Indeed, as the PTF recognized, providing adequate health care funding is the key to shoring up and improving VA health care. Many of the recommendations in the report will ultimately have very little effect if the VA funding structure is not reformed. Although the PTF must be commended for attempting to grapple with this issue, we are disappointed with the extent, and the scope, of their Recommendation 5.1.

This Recommendation states that the "Federal Government should provide full funding to ensure that enrolled veterans in Priority Groups 1 through 7 (new) are provided the current comprehensive benefit in accordance with VA's established access standards. Full funding should occur through modifications to the current budget and appropriations process, by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal."

PVA strongly agrees with the position advocated by task force members Alvarez and Wallace, which called for "guarantee[d] access and funding for Priority 8 veterans." The PTF, in their recommendation 5.3 merely called the uncertainty facing Priority Group 8 veterans "unacceptable" and urged the President and Congress to "work together to solve this problem," while excluding this from Recommendation 5.1. We also note that task force members Spanogle, Walters and Fleming also urged continued access and health care for Priority Group 8 veterans. PVA believes the Priority 8 veterans must be included in any guaranteed funding mechanism developed for Priority 1 through 7 veterans.

As stated before, the PTF called for full funding, "by using a mandatory funding mechanism, or by some other changes in the process that achieve the desired goal." One of two alternative mechanisms suggested by the PTF in regards to Recommendation 5.1 calls for the creation of an "impartial board of experts, actuaries, and others from outside VA to identify the funding required for veterans' health care that must be included in the discretionary budget request." This approach, while different from the mandatory funding mechanism we have become familiar with, is well worth investigation and full consideration. The panel of actuaries approach may be a valid solution to this long-standing funding problem. No well-intended concept should be disqualified out-of-hand if it is designed to produce the end result – the dollars needed to maintain the quality and quantity of veterans' health care. We congratulate Chairman Smith for his advocacy and leadership on this issue in introducing legislation bringing this new funding concept to the table.

There really is no mystery concerning the amount of funding needed by the VA health care system. PVA has, along with AMVETS, Disabled American Veterans, and the Veterans of Foreign Wars, published *The Independent Budget*, now in its 17th year, which provides an independent assessment of the VA's true resource requirements. Indeed, even the VA comes somewhat close at times, if you strip away OMB's artificial budget caps, all the far-fetched policy initiatives, wildly overstated numbers regarding third-party collections and such things as the perennially popular "management efficiencies."

For this reason, PVA must again restate our support for guaranteed mandatory funding of VA health care. This was the second of the two alternative approaches identified by the PTF:

> In recent years, legislation has been introduced to require mandatory funding for VA health care as a possible solution. This approach would require that VA be funded in a given year based on a capitated formula established in authorizing language. Funds would continue to be allocated as part of the Department's annual funding process; however, the funding requirement would not be subject to the agency budget development process, but based on the number of veterans enrolled as of a given date. While this or a similar methodology would not guarantee access, it would likely eliminate one of the major impediments to providing access: unpredictable or subjectively developed budget requests.

PVA strongly believes that some form of mandatory funding system is the only realistic solution to the VA's budget woes. We would also commend Ranking Democratic Member Lane Evans (R-IL) for introducing legislation, H.R. 2318, calling for mandatory funding for health care for all currently eligible veterans. Guaranteed, mandatory funding is an approach recommended by veterans' groups, and supported by many of you on this Committee. We urge this Committee and this Congress to quickly adopt a guaranteed funding approach for VA health care.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2003

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $220,000 (estimated).

Fiscal Year 2002

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $179,000.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $242,000.

RICHARD B. FULLER

Richard B. Fuller is the National Legislative Director of the Paralyzed Veterans of America (PVA), a non-profit veterans service organization chartered by the United States Congress to represent the interests of its members, veterans with spinal cord injury or dysfunction, and all Americans with disabilities. PVA's primary legislative focus centers on issues supporting the Department of Veterans Affairs health care system and the specialized services VA provides to PVA members. He is responsible for coordinating the organization's legislative and oversight activities on all veterans' benefits and services, as well as oversight on all federal health systems – Medicare and Medicaid – and research activities which benefit veterans as well as all Americans with disabilities.

Mr. Fuller served for eight years on the professional staff of the Committee on Veterans' Affairs of the U.S. House of Representatives with primary responsibilities in areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research and provider non-profit organizations in Washington, DC.

Mr. Fuller was Director of Public Affairs of the House Committee on Veterans' Affairs from 1979-1981. He served on the professional staff of the Subcommittee on Education, Training and Employment and for the Subcommittee on Hospitals and Health Care until 1987. In 1987, he joined the national government relation's staff of PVA, serving first as Associate Legislative Director, and then as National Legislative Director. In 1991, he joined a Washington D.C. health care consulting firm representing the public policy and legislative interests of several national medical and research societies, including: the American Federation for Clinical Research; the American Gastroenterological Association; the American Geriatrics Society; and the National Association of Veterans Research and Education Foundations. He returned to PVA in 1993 to lead the organization's outreach efforts on national and state health-care reform.

Mr. Fuller graduated with a Bachelor of Arts degree from Duke University in 1968. He served in the United States Air Force from 1968-1972, stationed two and one-half years in Vietnam and Southeast Asia as an aircrew Vietnamese linguist with the Air Force Security Service.